

MDR Tracking Number: M5-05-1650-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 2-9-05.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The electrical stimulation, ultrasound, therapeutic exercises and therapeutic activities from 9-20-04 through 10-1-04 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees totaling \$1111.08 from 9-20-04 through 10-1-04 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is hereby issued this 21st day of April 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

April 15, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-05-1650-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in Family Practice which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1978. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 43 year-old male injured his back on ____ in a work related incident. He has been treated with therapy and medications.

Requested Service(s)

Electrical stimulation, ultrasound, therapeutic exercises, therapeutic activities for dates of service 09/20/04 through 10/01/04

Decision

It is determined that there is medical necessity for the electrical stimulation, ultrasound, therapeutic exercises, and therapeutic activities for dates of service 09/20/04 through 10/01/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates this patient has had an improvement in function and is able to lift light objects as of September of 2004. There is no medical documentation this could be done prior to the dates of service in question. Because of these improvements in function, it is determined the electrical stimulation, ultrasound, therapeutic exercises, and therapeutic activities for dates of service 09/20/04 through 10/01/04 were beneficial and therefore medically necessary to treat this patient's medical condition.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-1650-01

Information Submitted by Requestor:

- Progress Notes
- Treatment Notes
- Diagnostic Tests
- Functional capacity evaluation

Information Submitted by Respondent:

- Progress Notes
- Treatment Notes
- Functional capacity evaluation
- Diagnostic Tests
- Impairment Rating
- Claims
- Investigation/surveillance
- Past Medical Records